Manual and Recognition Program

Integrated Diabetes Education and Clinical Standards Recognition Program for American Indian and Alaska Native Communities

"A system to assure quality diabetes services for your community"

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Indian Health Service Integrated Diabetes Education and Clinical Standards Recognition Program

"A system to assure quality diabetes services for your community"

Thank you for choosing the Indian Health Service (IHS) *Integrated Diabetes Education and Clinical Standards Recognition Program.* The IHS Recognition Program enables you to seek recognition of quality diabetes education and care services offered within your community. The IHS Recognition Program offers you flexibility in measuring your program success against nationally accepted standards.

The IHS recognition program allows you to build program success by using a three-stage approach:

Level 1 - Developmental
Completion of all elements at this level shows your community that your health services are starting work to develop a quality diabetes program.

Level 2 - Educational
Completion of all elements at this level shows your community that you provide quality diabetes education services.

Level 3 - Integrated Diabetes Program
Completion of all elements at this level shows your community that you provide quality diabetes education, clinical and public health services. Recognition at this level is the best you can be! It means that your facility offers the best in diabetes care and education practices. This includes community-wide prevention programs, diabetes clinical systems and educational programs for people with diabetes and their families.

This manual was developed to assist you in meeting your diabetes recognition needs. We use the National Standards for Diabetes Self-Management, May 2000, as the framework for the manual. Each of the ten standards is divided into three sections: developmental, educational and the integrated public health approach. Programs applying for the *IHS Diabetes Education Program Recognition* must meet the review criteria listed in the developmental (level 1) and educational (level 2) sections. Programs also have the choice to apply for the *IHS Integrated Diabetes Program Recognition* by meeting the review criteria elements at all levels.

Background

We developed the *IHS Integrated Diabetes Education and Clinical Standards Recognition Program* to allow flexibility for Indian health programs (IHS, tribal and urban) to show quality diabetes programming -- within the parameters of their health care infrastructure. IHS recognition will allow education programs that serve American Indian/Alaska Native communities to seek Medicare reimbursement.

Since 1984, the IHS National Diabetes program has endorsed the National Standards for Diabetes Education. In 1986, a task force of representatives from Indian health diabetes programs identified review criteria to guide diabetes program development and recognition within American Indian and Alaska Native communities. Besides the National Standards for Diabetes Education, the IHS National Diabetes Program task force included the IHS Standards of Care for Patients with Type 2 Diabetes. Review criteria included factors effective for quality diabetes programs within tribal communities. Thus, the *Integrated Diabetes Education and Clinical Standards Recognition Program for American Indian and Alaska Native Communities* was developed.

The IHS National Diabetes Program task force reconvened in the fall of 2000 to revise the IHS Integrated Diabetes Education and Care Standards and Recognition Program. The updated program reflects the most current National Standards for Diabetes Self-Management Education (May 2000). We continue to integrate the IHS Standards of Care for Patients with Type 2 Diabetes (March 2001) and other factors effective for quality diabetes programs within tribal communities.

The IHS Recognition Program enables you to seek recognition for quality diabetes care and education services in a way that best suits your community needs. Programs applying for the *IHS Diabetes Education Program Recognition* must meet the review criteria listed in the developmental (level 1) and educational (level 2) sections. Programs also have the choice to apply for the *IHS Integrated Diabetes Program Recognition* by meeting the review criteria elements at all three levels.

How to Use This Manual

We have developed a three-stage approach that provides Indian health diabetes teams some flexibility in planning for program recognition. The manual is organized by sections:

Section one (pages 5-17) contains each of the ten standards and review criteria. You will see that review elements for each standard are divided into three levels:

developmental --The review elements at this level provide your program with a framework to build the infrastructure and capacity necessary to sustain a quality diabetes program.

educational -- The review elements at this level continue to help your program identify the structure, process and outcome indicators that point to a quality diabetes self-management education program.

Programs completing the developmental and education levels can apply for IHS Diabetes Education Program Recognition.

and, the integrated public health approach -- Completion of all elements at this level shows your community that your facility provides quality diabetes education, clinical services and public health practices. Completing all of the elements at this level means you provide exceptional diabetes education and care to the community.

Programs completing all three levels can apply for IHS Integrated Diabetes Program Recognition.

Section two (pages 18-22) contains definitions and terms used in the manual, a list of IHS Diabetes Centers and Model Programs, and a list of IHS Area Diabetes Consultants and Advisors.

Section three (pages 23-30) contains the National Standards for Diabetes Self-Management Education and IHS Standards of Care for Patients with Type 2 Diabetes.

Section four (pages 31-37) contains a checklist, with each standard and review element listed by level -- developmental (level 1), educational (level 2) and public health (level 3). You may want to use this checklist to "rate" your program and identify gaps.

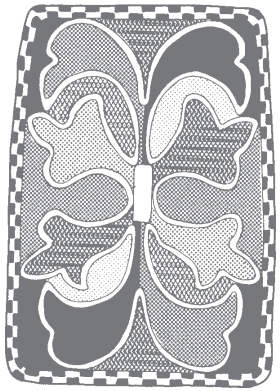
Section five (pages 38-47) contains a Diabetes Program Review Application and Instructions.

Section six (pages 48-56) contains sample forms including Healthy Behavior Form, Diabetes Health Assessment Form, and Indian Health Diabetes Self-Management Education Referral Form.

As you prepare for IHS Diabetes Program Recognition, please check the IHS National Diabetes Program web site at: www.ihs.gov/medicalprograms/diabetes for updates.

Section 1

IHS Integrated Diabetes Care and Education Standards and Review Criteria



Standard 1

The Indian health diabetes self- management education entity documents an organizational structure, mission statement and goals, and will recognize and support quality diabetes self-management education as an integral component of diabetes care.

Standard One -- Review Criteria

Level 1 -- Developmental

Team

A diabetes team structure and process are identified (composition of team, meeting place/time/frequency, roles/responsibilities, etc.). At a minimum, the team shall consist of a primary care provider (MD, DO, NP, PA), registered nurse and registered dietitian. Other appropriate staff may be members of the team (pharmacist, health educator, mental health, medical technologist, public health nurse, community health representative, community members, health board members, etc.). Emphasis at this stage is the education component.

Registry

A registry of all people served by the program (entity) with diabetes is in place. Registry information shall follow standard data guidelines suggested by the IHS National Diabetes Program and IHS Area Diabetes Consultant. Registry documentation should include the process used for annual updates. See pages 22-23 for Area Diabetes Consultant (ADC) listing. Your ADC can help you with your registry assessment.

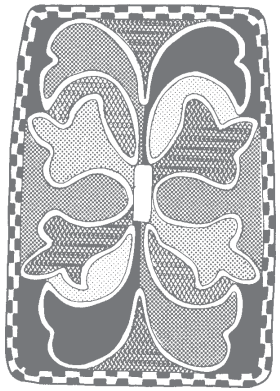
Organizational Chart

Discussions begin to place the diabetes program within the appropriate administrative organizational structure.

Program Manual

A program manual is being developed which includes an overall program description, policies, mission statement, goals, annual plan, organizational chart, team member roles and responsibilities, education program structure, forms etc. The manual will also include the following supporting documents:

- Team Commitment -- A written statement that affirms the use of a team to deliver diabetes self-management education.
- Administrative Commitment -- A written statement signed by an appropriate official(s), which affirms diabetes self-management education as an integral component of diabetes care.
- Tribal Commitment -- A written statement affirming the tribe's commitment to diabetes self-management education. Statement can be in the form of a letter, tribal resolution or found in the mission statement.



Standard 1

The Indian health diabetes self- management education entity documents an organizational structure, mission statement and goals, and will recognize and support quality diabetes self-management education as an integral component of diabetes care.

Standard One -- Review Criteria (cont.)

Level 2 -- Educational

Team

Meetings are documented and conducted on a scheduled basis. Monthly team meetings are encouraged. At a minimum, team meetings occur on a quarterly basis. Meeting minutes should document evidence of:

- role definition and responsibilities,
- communication among team members regarding program policies and goals and other educational issues,
- coordination/consistent approach to interpreting diabetes concepts,
- coordination between appropriate departments.

Registry

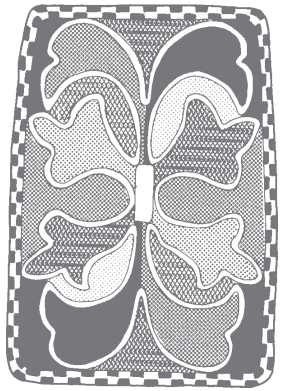
There is evidence that the diabetes registry is updated annually. There is evidence that the diabetes education team assesses the registry and uses information for annual planning.

Organizational Chart

The diabetes education program is recognized in the organizational structure of the facility. The line of authority for the diabetes education program team and/or staff is identified.

Program Manual

Program manual complete (contains all necessary documentation supporting educational program, including organizational structure, mission statement, goals, annual plan, description of educational team and educational process, follow-up and other program components). Approval mechanisms for both policy and program changes are clearly defined. There is evidence that the program manual is reviewed annually and signed by appropriate individuals.



Standard 1

The Indian health diabetes self- management education entity documents an organizational structure, mission statement and goals, and will recognize and support quality diabetes self-management education as an integral component of diabetes care.

Standard One -- Review Criteria (cont.)

Level 3 -- Integrated Public Health Approach

Team

Team membership includes clinical, educational, public health and community representatives (as appropriate to the facility). Team minutes reflect a coordinated approach to diabetes management and education. There is evidence of the integration of diabetes education and medical standards.

Registry Evidence

General diabetes registry, complication and other registries appropriate for the community (impaired glucose tolerance, gestational, ESRD, hypertension, etc.) are in place and updated annually.

Organizational Chart

The diabetes program is recognized in the organizational structure of the facility.

Program Manual

The program manual describes educational, clinical and public health components for diabetes prevention and management. The manual also includes documentation of:

- Team commitment. The National Standards for Diabetes Self-Management Education (May 2000) and the IHS Standards of Care for Patients with Type 2 Diabetes (March 2001) are endorsed by all team members.
- Administrative commitment. The National Standards for Diabetes Self-Management Education (May 2000) and the IHS Standards of Care for Patients with Type 2 Diabetes (March 2001) are endorsed by the appropriate health care administration.
- Tribal commitment. There is a written statement in place affirming the tribe's commitment to address diabetes prevention and management (e.g., resolution, letter from tribal administration).

Standard 2

The Indian health diabetes education entity will determine its target population, assess educational needs, and identify the resources necessary to meet the self-management educational needs of the target population.

Standard 2 -- Review Criteria

Level 1 -- Developmental

Education Program

Tasks that need to be accomplished in order to develop an education program are identified and outlined.

Assessment

The program describes its target population (newly diagnosed, gestational, elders, youth, etc.), documents assessment activities, describes educational needs of target population(s) and identifies program goals and objectives.

Resource Requirements

The program identifies the space, staffing, budget, instructional materials, staff education and other resources needed to develop and maintain the diabetes education program. There is evidence of an assessment process to identify education resources and interventions known to be successful for American Indian/Alaska Native communities.

Level 2 -- Educational

Annual Goals and Objectives

There is evidence of annual program goals and objectives which are realistic, measurable and consistent with the needs of the population served. Team meeting agendas/minutes reflect tracking and progress towards annual goals/objectives. Resources are provided to meet identified goals and objectives.

Target Population

There is evidence that diabetes self-management services meet the needs of the target population. Evidence can include team minutes, population assessments, community surveys, marketing brochures and other related materials.

Resource Requirements

There is evidence of ongoing resource assessment as programs expand to meet community needs.

Access to Care

There is evidence that the Indian health diabetes education entity defines how a consumer gains access to care. Evidence can include documentation in team minutes and/or program manual. Documentation should include a short description of community access challenges/barriers and methods or strategies used to improve access.

Standard 2

The Indian health diabetes education entity will determine its target population, assess educational needs, and identify the resources necessary to meet the self-management educational needs of the target population.

Standard 2 -- Review Criteria (cont.)

Level 3 -- Integrated Public Health Approach

Diabetes prevention and control services are considered at three levels:

- Primary Level: The maintenance of health by removal of precipitating causes and determinants of departures from good health.
- Secondary Level: The early detection and management of disease before it has time to progress and cause irreversible damage.
- Tertiary Level: Preventing deterioration and complications from occurring when disease or disability are already established.

Annual Goals and Objectives

Community assessment information is expanded and utilized for annual planning. Diabetes team develops goals and objectives based on assessment information. Methods shall include use of information (community profiles, surveys, diabetes audit data, complications, etc.) obtained from various assessment activities (tribal administration services, clinical or other public health approaches). There is evidence of community-based and clinical diabetes prevention programs.

Target Population

There is evidence that diabetes self-management services meet the needs of the target population. Evidence can include team minutes, population assessments, registry analysis, etc.

Resource Requirements

There is evidence of ongoing resource assessment as the program expands to meet community needs.

Access

The program defines how a community member gains access to the education and clinical services (referral, self-referral, etc.). Community access issues for both educational programs and clinical services are further defined and documented. Marketing strategies are developed to help increase access to educational and clinical services.

Community Prevention

There is evidence of community-based prevention activities to promote healthy lifestyles (examples: school health, elder programs, community group education, community healthy cooking classes, etc.).

Clinical Care

There is a system in place for maintaining continuity of care. This includes a mechanism to identify cases lost to medical and educational follow-up. The utilization of follow-up services is tracked.

Standard 3

An established system (committee, governing board, advisory board) involving professional staff and stakeholders will participate annually in a planning and review process that includes data analysis and outcome measurements, and addresses community concerns.

Standard 3 -- Review Criteria

Level 1 -- Developmental

Advisory Body

Program identifies advisory body(s) and documents communication. Advisory body(s) reflects community served. Examples of an advisory body are Tribal Health Board, Governing Body, Tribal Council, Wellness Committee; or, programs may create a new advisory system. Members should represent both medical/educational and community/consumer groups. Multiple advisory bodies are acceptable, based on established systems within communities (i.e. issues regarding diabetes education with seniors may be addressed by both Tribal Health Board and Elder Committee, issues with school health may be addressed by school board and/or Tribal Council.) Minutes should reflect advisory body selection, approaches/methods used to seek advice and outcomes.

Level 2 -- Educational

Advisory Body

There is a process that provides community and other advisory member input to the education program, including curriculum and annual program plan, at regular intervals, but at least annually.

Level 3 -- Integrated Public Health Approach

Advisory Body

The advisory body(s) has the opportunity to review and comment on diabetes programs including curriculum, annual program plan and audit results. There is evidence that policy recommendations have been forwarded to the administrative unit for approval and signatures.

Standard 4

The Indian health diabetes education entity will designate a coordinator with academic and/or experiential preparation in program management and the care of individuals with chronic disease.

The coordinator will oversee the planning, implementation and evaluation of the Indian health diabetes education entity.

Standard 4 -- Review Criteria

Level 1 -- Developmental

Coordinator

A coordinator is identified. The coordinator is a credentialed health professional with appropriate education and experience. The coordinator's responsibilities and line of authority are defined. Documentation of coordinator's credentials, roles and responsibilities, and line of authority is found in the program manual.

Level 2 -- Educational

Coordinator

The coordinator manages the following team efforts:

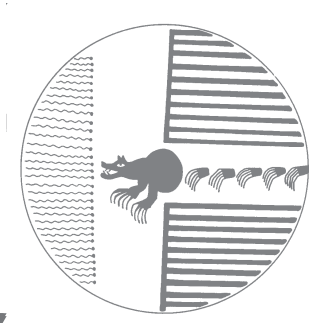
- development of goals and objectives,
- planning and implementation of program activities,
- evaluation of program content and outcome.

The coordinator acts as the diabetes education liaison between team members, departments or programs and the community. The responsibilities shall be reflected in the position description and employee performance appraisal system (urban, tribal or IHS). The coordinator documents a minimum of twelve (12) hours every two years of continuing education in diabetes, educational principles or leadership/management. Continuing education content and distribution of hours should be based on professional discretion.

Level 3 -- Integrated Public Health Approach

Coordinator

The coordinator acts as a liaison between multidisciplinary team, programs and departments providing comprehensive services for individuals with diabetes and their families. The coordinator manages the diabetes education program and is a leader or team member in clinical and/or community diabetes programming. Coordinator leads or helps organize diabetes chart audits and surveillance systems (prevalence, complications, etc.), coordination of consumer care services, orientation of clinical staff, field health, tribal and other personnel to diabetes programs, and program budget preparations.



Standard 5

The Indian health diabetes education entity will involve the interaction of the individual with diabetes with a multifaceted instructional team, which may include a behaviorist, exercise physiologist, ophthalmologist, optometrist, pharmacist, physician, podiatrist, registered dietitian, registered nurse, other health care professionals and paraprofessionals.

The instructional team is collectively qualified to teach the content areas. The instructional team must consist of at least a registered dietitian and a registered nurse. At least one of the instructional staff must be Certified Diabetes Educators (CDE), OR have recent didactic and experiential preparation in education and diabetes management.

Standard 5 -- Review Criteria

Level 1 -- Developmental

Instructors

Diabetes program team members with knowledge and skill in diabetes education are identified and appointed as the instructional team. The program manual will include listing of instructional staff, credentials, roles and responsibilities. Indian health instructional teams must include a registered nurse and a registered dietitian.

Facilities, with documented justification, may include off-site professional staff /consultants (local contract, Area Consultants, Model Diabetes Program staff, etc.) as instructional team members. Their role and responsibility on the instructional team is based on community needs and documented in team minutes or in the program manual. These facilities must have at least one RN or RD staff available for direct one-on-one or group education services.

Level 2 -- Educational

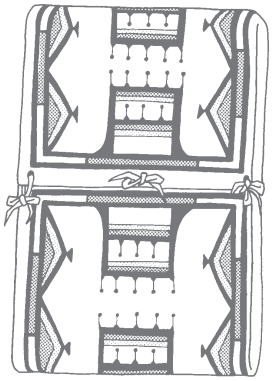
Instructors

Instructors provide educational program services for the target population. Instructors use a variety of teaching learning methods to meet the needs of the individual, family and community, and evidence of this will be included in education program agendas and curricula outlines. There is evidence that the team advocates a consistent and coordinated approach to present basic diabetes concepts. This approach is promoted by review of education materials, teaching methods and activities.

Level 3 -- Integrated Public Health Approach

Diabetes Team

Instructional team is able to provide multifaceted level of diabetes education that includes integration of traditional and western methods of teaching/learning activities. Components can include talking circles, youth prevention groups, case management, elder teaching, increased use of paraprofessionals and other strategies appropriate within community and cultural systems.



Standard 6

The Indian health education entity instructors will obtain regular continuing education in the areas of diabetes management, behavioral interventions, teaching and learning skills, and counseling skills.

Standard 6 -- Review Criteria

Level 1 -- Developmental

Instructors

There is evidence that instructors are familiar with diabetes and its management in American Indian/ Alaska Native populations and have the knowledge, skills and abilities in behavioral interventions, teaching/learning and counseling/communication methods.

Level 2 -- Educational

Instructors

There is evidence that instructors maintain a minimum of twelve (12) continuing education hours every two years in diabetes management, behavioral interventions, teaching and learning skills, and counseling skills. Continuing education content and distribution of hours should be based on professional discretion.

Level 3 -- Integrated Public Health Approach

Diabetes Team

There is evidence that diabetes team members participate in yearly diabetes management, behavioral interventions, teaching and learning or counseling skills workshops and in-service programs relevant to diabetes in American Indians /Alaska Natives.

Standard 7

A written curriculum, with criteria for successful learning outcomes, shall be available. Assessed needs of the individual will determine which content areas are delivered.

Standard 7 -- Review Criteria

Level 1 -- Developmental

Curricula

Available diabetes education curricula are identified and reviewed. There is evidence that the accepted curricula is reviewed and modified to fit community needs. Curricula will include written and measurable learning objectives, a content outline, instructional methods, materials, and means of evaluating the achievement of objectives. Content will include:

- Describing the diabetes disease process and treatment options
- Incorporating appropriate nutritional management
- Incorporating physical activity into lifestyle
- Utilizing medications (if applicable) for therapeutic effectiveness
- Monitoring blood sugar, urine ketones (if applicable), and using the results to improve control
- Preventing, detecting, and treating acute complications
- Preventing (through risk reduction behavior), detecting, and treating chronic complications
- Goal setting to promote health, and problem solving for daily living
- Integrating psychosocial adjustment to daily life
- Promoting preconception care, management during pregnancy, and gestational diabetes management (if applicable)

Level 2 -- Educational

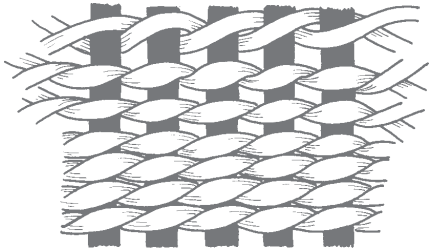
Curricula

The curricula and other education program resources/materials are reviewed annually by instructors for scientific accuracy and cultural relevancy. New materials used in the education program are field-tested for relevance and comprehension. Interpreters (if used) are oriented on an established basis.

Level 3 -- Integrated Public Health Approach

Curricula

There is evidence of medical, public health staff and community participation in curricula review and adaptation. Evidence can include medical staff minutes, memos or integration of diabetes care and outcomes audit analysis. Community input can be documented with consumer feedback, focus groups, field testing, survey or other methods.



Standard 8

An individualized assessment, development of an educational plan, and periodic reassessment between participant and instructor(s) will direct the selection of appropriate educational materials and interventions.

Standard 8 -- Review Criteria

Level 1 -- Developmental

Assessment Form

Instructional team develops an individualized educational needs assessment process and form for documentation. Indian health facilities may use a standard IHS form, formatted PCC form or approved medical record form. All forms must include information on relevant medical history, cultural influences, health beliefs and attitudes, diabetes knowledge/skill, readiness to learn, preferred learning methods, barriers to learning, family support and financial limitations.

Level 2 -- Educational

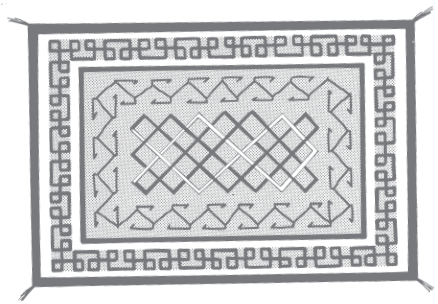
Educational Assessment

Instructional team adopts a standard diabetes education assessment process and documentation form. This completed form is used as the tool to guide the individual educational process, which includes an initial and ongoing educational plan. Educational assessment is done on an individual basis. Instructor develops learning objectives and educational plan with the client. Client identifies behavioral objectives with guidance from instructional team. Instructional team uses educational assessment as a basis of all educational plans, interventions and material selection. Instructional team documents periodic reassessment of individuals in case load.

Level 3 -- Integrated Public Health Approach

Coordinated Diabetes Care and Education

The multidisciplinary diabetes care and education team uses case management, or other organizational diabetes best practice systems, which coordinates the ongoing diabetes care and education needs of individuals on a consistent basis.



Standard 9

There shall be documentation of the individual's assessment, education plan, intervention, evaluation, and follow-up in the permanent, confidential education record.

Documentation also will provide evidence of collaboration among instructional staff, providers, and referral sources.

Standard 9 -- Review Criteria

Level 1 -- Developmental

Documentation Systems

Educational documentation methods (PCC, RPMS) and other educational forms are reviewed and modified for program use. There is evidence that instructional staff are familiar with education codes (RPMS preferred). SOAP charting is the accepted documentation method for educational interventions. There is a process defined in the policy and procedure manual regarding transfer of confidential medical record information.

Level 2 -- Educational

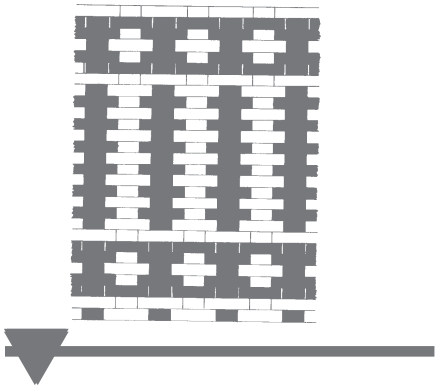
Medical Record

There is evidence of documentation of the teaching process including assessment, planning, implementation, and evaluation of the individualized educational experience. All information about an individual's diabetes education contacts will be maintained in the medical record. Medical record documentation shows evidence of collaboration among educational team, providers and other diabetes personnel. Educational codes are used in facilities with RPMS. Documentation can include case management reviews, referrals and referral summaries, follow up notices, plan of education or care, etc.

Level 3 -- Integrated Public Health Approach

Medical Record

All information about an individual's diabetes education and clinical care will be maintained in the medical record. All team members receive orientation and updates to diabetes documentation and coding issues within facility. Documentation includes community services.



Standard 10

The Indian health diabetes education entity will utilize a continuous quality improvement process to evaluate the effectiveness of the education experience provided, and determine opportunities for improvement.

Standard 10 -- Review Criteria

Level 1 -- Developmental

Evaluation

There is documentation of education program goals and objectives. Proposed evaluation design will include both behavioral and clinical indicators.

Consumer Satisfaction

Mechanisms for evaluating consumer satisfaction of educational services are evident.

Level 2 -- Educational

Evaluation

There is documentation of education program impact and outcome evaluation data which measures progress in achieving education program goals and objectives. Documentation includes:

- Input from diabetes team, health care providers and consumers,
- Program records documenting population served, types of services (individual/group, initial/continuing/follow-up), length of participation, setting, content (PCC codes), age categories, etc.
- Evaluation process used for a minimum of one(1) behavioral and two(2) clinical indicators,
- Modifications made or action taken as a result of program evaluation and consumer feedback

Level 3 -- Integrated Public Health Approach

Diabetes Care and Outcomes Audit

There is evidence that a diabetes care and outcomes audit is conducted annually. Specific educational indicators are included in the diabetes care and outcomes measures. Educational indicators are modified or expanded annually within the facilities capabilities.

Diabetes Prevention Programs

There is evidence that community diabetes prevention programs have an annual program evaluation or surveillance component in place.

Evaluation Results

There is evidence that continuous quality improvement data are shared with established advisory body, appropriate tribal leaders, community systems promoting diabetes prevention, and the tribal community. The results of these evaluations shall be used in subsequent planning and program modification.

Section 2

Definition of Terms

IHS Model Diabetes Model Programs

IHS Area Diabetes Consultants and Advisors

Definition of Terms

Advisory Body - A method that seeks guidance and counsel from community representatives, health care administrators and professionals re: diabetes educational, clinical and public health programs within the community.

Annual plan - Documentation that describes program goals, objectives, implementation process and methods, resource requirements/budget, consumer access and evaluation methods. Diabetes team uses the annual plan to monitor activities and outcomes.

Behavioral objective - Medical record documentation of a patient identified behavior that he/she is willing to change. The individual behavioral objective should be realistic and measurable.

CEU - Continuing education unit. Documented in hours of continuing education activity. Includes CEU from accredited organizations and certificates of attendance at diabetes related inservices, regional meetings, etc. It is expected that professional staff will document majority of accredited CEU. Paraprofessional staff may have greater mix of accredited and non-accredited CEU.

Community - The social, cultural, political and geographic environment within which the Indian health facility offers services.

Consistent - Diabetes team members use the same terms, materials and descriptors when educating the community, individuals or families; "everyone is getting the same message."

Consumer access - A policy and process used to instruct providers, individuals and families about how to receive educational, clinical or public health services.

Coordinated - Diabetes team works together in program planning, implementation and evaluation.

Educational plan - Medical record documentation of individual assessment, learning and behavioral objectives and evaluation. SOAP format preferred.

Goal - A statement that defines program aim or purpose.

IHS Diabetes Care and Outcomes Audit - A diabetes care surveillance system that tracks performance on more than 87 indicators to study trends over time. The system is based on IHS Standards of Diabetes Care (pages 25-30) updated every two years. Information and directions for incorporating this system can be found at: www.ihs.gov/medicalprograms/diabetes.

Instructional material - Any material used in educational programming including pamphlets, audio-visual, models, etc.

Individualized educational assessment - The process used to identify learning needs with an individual; includes relevant medical history, diabetes history, risk factors, cultural influences, health beliefs and attitudes, barriers to learning, health behavior goals, support systems and other socioeconomic factors. Most information should be gathered during an interactive interview with the diabetes educator.

Instructors - Health care professionals with knowledge, experience and demonstrated skill in diabetes self-management education process within AI/AN communities.

Integrated Indian Health Diabetes Education Program - A quality diabetes education program that meets the National Standards for Diabetes Self Management Education. The program operates within American Indian or Alaska Native communities and provides integration of diabetes education standards within community system.

Integrated Public Health Approach - Indian health diabetes program that offers quality diabetes education, clinical and public health services to consumers.

Learning objective - Medical record documentation of diabetes education aim and purpose based on individual assessment.

Objective - A statement that defines how programs will achieve the aim or purpose.

Periodic assessment - A set period for evaluation of program services.

Program manual - Documentation that describes policies, procedures and other facility systems created to enhance diabetes education, clinical care and public health services within the community.

Resources - Materials, systems, professionals, consultation, technical or public health services available in community to enhance, support or assist diabetes self-management.

Stakeholders - Community members, individuals and families eligible for diabetes education, clinical or public health services.

Surveillance - Data obtained within a set period (quarterly, annually, weekly, etc.).

Target population - That group of individuals and families who have the characteristics that the diabetes program defines as program participants (elders, youth, people with neuropathy, etc.).

IHS Model Diabetes Programs

Alaska Diabetes Program
Ann Marie Mayer, Coordinator
Alaska Native Medical Center - Diabetes
4315 Diplomacy Drive
Anchorage, Alaska 99508
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FAX: (907) 729-1129

Albuquerque Diabetes Program
Lani Desaulniers, Actg. Coordinator
PHS Indian Hospital
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FAX: (505) 248-7697

Blackfeet Diabetes Program
Debbie Powell-Taylor, Coordinator
Blackfeet Community Hospital
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Browning, Montana 59417
Phone: (406) 338-6305
FAX: (406) 338-6195 FAX: (505) 248-7697

Claremore Diabetes Program
Eileen Wall, Coordinator
PHS Indian Hospital
Claremore, OK 74017
Phone: (918) 342-6451
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Section 3

National Standards for Diabetes Self-Management Education-May 2000

IHS Standards of Care for Patients with Type 2 Diabetes April 2001

Problem Statement

Diabetes Self-Management Education (DSME) is the cornerstone of care for all persons with diabetes who want to achieve successful health related outcomes. The National Standards for DSME are designed to define quality diabetes self-management education that can be implemented in diverse settings and will facilitate improvement in health care outcomes. The dynamic health care process obligates the diabetes community to periodically review and revise these Standards to reflect advances in scientific knowledge and health care.

Therefore, the Task Force to review the National Standards for DSME was convened to review the current Standards for their appropriateness, relevancy, and scientific basis, and to be sure they are specific and achievable in multiple settings. Task Force Organizations, Federal Agencies, and Federally Funded Programs included:

- American Diabetes Association
- American Association of Diabetes Educators
- The American Dietetic Association
- Veteran's Health Administration
- Centers for Disease Control and Prevention
- Indian Health Service
- National Certification Board for Diabetes Educators
- Juvenile Diabetes Foundation International
- Diabetes Research and Training Centers

You can find the complete manuscript that outlines each education standard, supporting documentation, definition of terms and recommendations for future reviews in:

Mensing C, et.al. National Standards for Diabetes Self-Management Education, Diabetes Care, 23(5)682-689, 2000.

The following is a listing of each standard by category:

Structure

Standard 1

The DSME entity will have documentation of its organizational structure, mission statement and goals, and will recognize and support quality diabetes self-management education as an integral component of diabetes care.

Standard 2

The DSME entity will determine its target population, assess educational needs, and identify the resources necessary to meet the self-management educational needs of the target population(s).

Standard 3

An established system (committee, governing board, advisory body) involving professional staff and other stakeholders will participate annually in a planning and review process that includes data analysis and outcome measurements, and addresses community concerns.

Standard 4

The DSME entity will designate a coordinator with academic and/or experiential preparation in program management and the care of persons with chronic disease. The coordinator will oversee the planning, implementation and evaluation of the DSME entity.

Standard 5

DSME will involve the interaction of the individual with diabetes with a multifaceted education instructional team, which may include a behaviorist, exercise physiologist, ophthalmologist, optometrist, pharmacist, physician, podiatrist, registered dietitian, registered nurse, other health care professionals and paraprofessionals. DSME instructors are collectively qualified to teach the content areas. The instructional team must consist of at least a registered dietitian and a registered nurse. Instructional staff must be Certified Diabetes Educators (CDE), or have recent didactic and experiential preparation in education and diabetes management.

National Standards for Diabetes Self-Management Education (continued)

Standard 6
The DSME instructors will obtain regular continuing education in the areas of diabetes management, behavioral interventions, teaching and learning skills, and counseling skills.

Standard 7
A written curriculum, with criteria for successful learning outcomes, shall be available. Assessed needs of the individual will determine which content areas listed below are delivered. Content will include:

- Describing the Diabetes Disease Process and treatment options
- Incorporating appropriate Nutritional Management
- Incorporating Physical Activity into lifestyle
- Utilizing Medications (if applicable) for therapeutic effectiveness
- Monitoring blood glucose, urine ketones (when appropriate), and using the results to improve control
- Preventing, detecting, and treating Acute Complications
- Preventing (through Risk Reduction behavior), detecting, and treating Chronic Complications
- Goal Setting to promote health, and Problem Solving for daily living
- Integrating Psychosocial Adjustment to daily life
- Promoting Preconception Care, management during Pregnancy, and Gestational Diabetes Management (if applicable)

Process

Standard 8
An individualized assessment, development of an education plan, and periodic reassessment between participant and instructor(s) will direct the selection of appropriate educational materials and interventions.

Standard 9
There shall be documentation of the individual's assessment, education plan, intervention, evaluation, and follow-up in the permanent, confidential education record. Documentation also will provide evidence of collaboration among instructional staff, providers, and referral sources.

Outcome

Standard 10
The DSME entity will use a continuous quality improvement process to evaluate the effectiveness of the education experience provided, and determine opportunities for improvement.

The Standards of Care for Type 2 diabetes have been developed and updated by the IHS National Diabetes Program to help provide consistent, quality care to patients with diabetes.

1 -- Baseline Studies

Height - Measure once and record on PCC Health Summary. If PCC is not available, record on diabetes flow sheet. For children <18 years of age, height and weight should be recorded at each visit. Use to calculate body mass index and ideal or reasonable body weight.

Date of Diabetes Diagnosis - Record on PCC Health Summary. If PCC is not available, record on diabetes flow sheet. Longer duration of diabetes correlates with increased risk of complications.

ECG - Obtain baseline then repeat every 1-5 years as clinically indicated (for those age 40 and above, or with diabetes duration over 10 years, every 1-2 years is recommended).

PPD - Should be documented once after diagnosis of diabetes. (Offer INH prophylaxis to patients according to protocol – refer to Section 9).

2 -- Each Clinic Visit

Blood Pressure - Target BP is ≤ 130/80. Additional protection against complications, including renal failure, may be obtained by lowering BP further.

Weight - Compare with measurements from prior visits to identify trends.

Blood Glucose - Results of lab determinations and self-monitoring should be available for timely discussion with the patient. Hemoglobin A1c (HbA1c) at 3-4 month intervals.

•Fasting/casual glucose measurement and self monitoring records should be available for timely discussion with the patient at each visit. Self-monitoring BG records are vital to diabetes management decisions.

•Determine if **HbA1c** has been performed within the past 3-4 months, and order if due.
•Patients in acceptable glycemic control (HbA1c ≤ 7.0%) should be tested at least every 6 months. HbA1c estimates the average degree of glycemic control over the preceding 3 months. HbA1c is the standard way to measure glycemic control.

•HbA1c results should be discussed with the patient at the time of the patient visit. If in-house measurement is unavailable, blood sample should be obtained several days before the clinic visit. At each clinic visit, the appropriate education, intervention, referral, and/or follow-up will be provided as indicated.

Foot Check - Inspection of feet and nails. Check for ingrown toenails, calluses, deformities, pressure points, ulcers, and cellulitis.

3 -- Annual

Creatinine - Screen for renal insufficiency.

Complete UA/Microalbuminuria - A test for urine protein should be performed yearly. If negative, a screening test for microalbuminuria should be performed (by A/C ratio or dipstick test). Dipstick-positive microalbuminuria should be confirmed on a separate specimen using an A/C ratio (abnormal ≥30mg/gm) or 24 hour urine. ACE inhibitors should be considered in patients with microalbuminuria or proteinuria, even if normotensive.

Lipid Profile

Risk factors for atherosclerosis include LDL >100, HDL <40 in men and <45 in women, and TG >200. Even lower LDL and TG values represent increased risk in persons with previously documented atherosclerosis. These risk factors, especially elevated LDL, should be treated aggressively. Caution should be used when considering agents that aggravate hyperglycemia.

A lipid panel should be performed annually (TC, LDL, HDL, TG). Consider direct LDL measurements, especially if TG >250 or if the specimen is to be obtained non-fasting. Elevated TC, LDL, TG and low HDL confer greater risk for atherosclerosis. Optimal LDL cholesterol levels for adults with diabetes are <100. All patients with LDL >100 require medical nutrition therapy and other lifestyle modifications. Pharmacologic intervention is recommended if dietary interventions and lifestyle modifications are ineffective in lowering LDL to <100.

Aspirin Therapy - Aspirin has been used as a primary and secondary prevention strategy to prevent cardiovascular events. Men and women with diabetes have a 2-4 fold increase in risk of dying from complications of cardiovascular disease (CVD). Aspirin in doses of 162-325 mg/day is recommended for patients with diabetes.

Strongly consider aspirin therapy as a primary prevention strategy in high risk men and women age 30 and above with diabetes. This includes individuals with family history of CVD, cigarette smoking, hypertension, obesity, albuminuria and dyslipidemia.

Use aspirin therapy as a secondary prevention strategy in diabetic men and women who have evidence of large vessel disease, such as history of MI, stroke, peripheral vascular disease, claudication or angina.

Eye Exam - Retinal exam through dilated pupils or fundus photo. Individuals with type 1 diabetes should receive an initial exam within 3-5 years of diagnosis once they are ≥ 10 years of age. People with type 2 diabetes should receive an exam at diagnosis, and yearly thereafter.

Dental Exam - Annual screen for periodontal disease and other oral pathology.

Foot Exam - Risk assessment to include pulse check and sensory evaluation with monofilament, identification of foot deformity, and documentation of history of foot ulcers.

Screen for Neuropathy - By history and physical; include sensory, motor and autonomic evaluation.

4 -- Immunizations and Skin Tests

Flu Vaccine - Yearly

Pneumovax - Vaccinate everyone at the time of diagnosis. Revaccination should be strongly considered five (5) years after the first dose for those patients at highest risk of fatal pneumococcal infection (e.g., asplenic patients) or those at highest risk of rapid decline in antibody levels (e.g., those with chronic renal failure, nephrotic syndrome, or transplanted organs). Revaccinate all patients ≥ age 65 years if it has been >5 years since initial vaccination.

Td - Every 10 years.

PPD - Once after diagnosis unless known positive. PPD-positive people with diabetes, including American Indians with Type 2 diabetes, have 5 times the risk of reactivating TB. All diabetic patients with positive PPD including those over age 35 should be given INH chemoprophylaxis according to current guidelines (see Section 9).

Hepatitis B -Vaccinate persons whose renal disease is likely to lead to dialysis or transplantation (serum creatinine ≥ 2.0).

5 -- Special Aspects of Diabetes Care

Lab Tests - C-peptide, the other half of pro-insulin, can evaluate a patient's endogenous insulin secretion and help distinguish between Type 1 and Type 2 diabetes. The test can be useful in at least two clinical situations:

1. Solving a clinical problem about using oral agents vs. insulin.

2. Evaluating a patient with history of ketoacidosis when stable (useful in setting of ETOH, acidosis, and diabetes to determine ongoing need for insulin).

6 -- Self-Care Education

Use of the PCC education codes to document education is encouraged.

Nutrition Education - Meal planning, nutrition education, and exercise are the primary treatment strategies for Type 2 diabetes. The Indian Health Service Diabetes Program supports the American Diabetes Association position that all persons with diabetes receive regular nutrition counseling and are seen by an RD/nutritionist every six months to 1 year. Some people may require more frequent evaluation and counseling.

Diabetes Education - All patients with diabetes and their families should have diabetes self-care information. The National Standards for Diabetes Care and Patient Education provide guidelines for education program development with criteria specific for American Indian/Alaska Native health care facilities. Every facility should work towards providing systematic mechanisms to make culturally relevant self-care information available for patients.

6 -- Self-Care Education (continued)

Exercise Education - Exercise is associated with improvement in both short- and long-term metabolic control. Exercise counseling should be provided to all persons with diabetes. The appropriate type of activity, including frequency, duration, and intensity, should be individualized for each patient.

Education and Glycemic Control

•Self monitoring results should be discussed with the patient at each visit.

•HbA1c results should be discussed with the patient within 2 weeks of the test, preferably at the patient visit.

Self-Blood Glucose Monitoring (SBGM) - The purpose of SBGM is to determine the pattern of blood glucose throughout the day. This pattern provides information for selection and adjustments in therapy. Frequency of monitoring must be individualized and may vary as day-to-day circumstances require.

7 -- Routine Health Maintenance

Physical Exam – Complete exam as baseline, then routine.

Pap Smear/Pelvic Exam – Yearly

Breast Exam – Yearly

Mammogram – Every 1-2 years in women ages 40-49, yearly thereafter.

Rectal Exam/Stool Guaiac – Yearly in adults ≥ 40 years of age.

Tobacco Use – Current tobacco use should be documented and a referral made for cessation of tobacco use.

8 -- Pregnancy and Diabetes

All women who are in their childbearing years should receive pre-pregnancy counseling for optimizing metabolic control prior to conception. Counseling for family planning is essential to achieve this goal.

American Indian women are at increased risk for developing gestational diabetes (GDM), as are women with certain other risk factors, including but not limited to the following:

•previous gestational diabetes
•previous fetal macrosomia
•unexplained stillbirth
•congenital anomaly
•obesity
•insulin resistance syndrome
•polycystic ovarian syndrome (PCOS)
•family history of diabetes

These women should be screened for GDM early in pregnancy. If early screening is negative, the screen should be repeated after at 24-28 weeks gestation.

8 -- Pregnancy and Diabetes (continued)

Women with GDM are at increased risk of developing type 2 diabetes (about one third of all AI/AN women with GDM will develop diabetes within 5 years). These women should be re-tested by OGTT at least 6-12 weeks post delivery to determine their glycemic status. Women with a normal postpartum OGTT should be re-tested every 1-3 years. Bear in mind that diagnostic standards for diabetes in breastfeeding women have not been established. Blood glucose should be monitored in the postpartum and lactating period, including regular self blood glucose testing, as clinically appropriate.

All women with a history of GDM should receive counseling/education regarding lifestyle modifications that will reduce or delay the development of type 2 diabetes. Moreover, the importance of maintaining optimal glucose control prior to and during any subsequent pregnancy should be stressed. Mothers should be made aware that children of GDM pregnancies should be monitored for obesity and abnormalities of glucose utilization. Further recommendations and guidelines for the screening, diagnosis and treatment of GDM may be found in the most recent *Clinical Practice Recommendations* of the American Diabetes Association (published annually) and Metzger BE, Coustan DR (Eds.): Proceedings of the Fourth International Workshop-Conference on Gestational Diabetes Mellitus. Diabetes Care 21 (Suppl. 2): B1-B167, 1998.

9 -- Tuberculosis and Diabetes Patients*

A "positive" PPD skin test (i.e., ≥10 mm induration 48-72 hours after administration) means that a person either has latent tuberculosis infection (LTBI) or active tuberculosis (TB) disease. Active TB disease needs to be ruled out prior to starting patients with LTBI on treatment. Treatment for active TB and LTBI are different*.

Patients with diabetes and LTBI are at high risk of progressing to active TB, if they are not treated for LTBI. Studies have shown that the risk is 2 to 6 times greater than in patients without diabetes. Other factors that further increase the risk for TB include: recent PPD conversion within 2 years, intravenous drug use, chest film showing prior active disease that was never treated, immunosuppressive drugs, and ESRD. Cutaneous anergy increases as patients age and develop complications of diabetes such as ESRD. Anergy may lead to false negative PPD test results.

In most cases progression of LTBI to active TB can be prevented by treatment with INH. In general, patients with diabetes who have a positive PPD (accurately read by a provider trained in interpretation of PPD) should

9 -- Tuberculosis and Diabetes Patients* (continued)

receive treatment for LTBI, *except* in the following circumstances:

•severe liver disease

•suicidal ideation

•adverse reaction to INH.

Patients receiving treatment for LTBI should be followed and monitored for potential hepatotoxicity. While national recommendations emphasize monitoring hepatotoxicity through systematic repetitive patient education and clinical evaluation for signs and symptoms of hepatotoxicity, baseline measurement of liver function tests and after one month should be considered, especially in patients receiving other potentially heptotoxic medications. Some experts recommend that INH be discontinued if transaminase levels exceed three times the upper limit of normal when associated with symptoms or five times the upper limit of normal if the patient is asymptomatic.

*Recommendations for targeted tuberculin testing and treatment of LTBI in MMWR, June 09, 2000/ 49(RR06); 1-54 or at: www.cdc.gov/mmwr//indrr_2000.html Treatment for active TB disease is detailed in: CDC Core Curriculum in TB: What the Clinician Should Know. CDC, 2000 (4th edition).

IHS TB Protocol for Patients with Diabetes:

• **Check the PPD status** of all patients with diabetes.

• If the **PPD status is negative or unknown**:

- PPD testing should be done within one year of initial work up for diabetes diagnoses, and treated if they have LTBI.

- If no PPD has been *placed* since the diagnosis of diabetes, and the patient's PPD status is negative or unknown, a PPD status needs to be ascertained.

- Subsequent PPD testing is done only if there is contact with an active TB case.

• If the **PPD status is positive**:

- Check for completion of past treatment for active TB or LTBI (6-9 months of INH for LTBI or multiple drug therapy for active disease).

- If the patient has not been adequately treated, search for active disease by history (weight loss, etc.), fever (record temperature) and recent chest x-ray (within 6 months). If there is no evidence of active disease, recommend treatment for LTBI (9 mos. of INH 300 mg daily) to all patients with diabetes, regardless of age, unless the patient has liver disease, suicide ideation or a previous adverse reaction to INH. Patients with diabetes should be given pyridoxine (10 -50 mg/day) with their INH. Consider directly observed therapy of LTBI when possible, especially for patients on dialysis.

Section 4

Checklist

Name of Person Filling Out:	Date:

STANDARD 1

	EVIDENCE YES	EVIDENCE NO
LEVEL 1		
Team members are identified and **meetings** are started		
Roles and responsibilities of team members are identified		
Required team composition (primary care provider, RN, and RD minimum) is in place		
Diabetes registry is in place		
Standard data guidelines used		
Annual update process identified		
Administration considers diabetes education program within the **organizational structure**		
Program manual started, including (at a minimum):		
General description of the education program		
Policies		
Mission statement		
Goals and annual plan		
Organizational chart		
Team member roles and responsibilities		
Education program structure		
Forms		
Written statements documenting:		
Team approach as integral component of diabetes education program		
Administrative commitment and support for team meetings, diabetes education instructors/staff, instructional time, preparation, implementation and evaluation.		
Tribal commitment and support for diabetes education program		
Evidence includes position descriptions, team meeting minutes, registry, organizational chart, program policies and Program Manual		

	EVIDENCE YES	EVIDENCE NO
LEVEL 2		
Team meets on a quarterly basis at minimum		
Team meetings are documented and include all of the following:		
Team member roles and responsibilities		
Communication among team members (critical issues tracked)		
Coordinated and consistent approach to interpreting basic diabetes concepts		
Coordination between appropriate departments		
Diabetes registry is updated annually		
Diabetes team assesses registry and uses it for annual planning		
Organizational chart shows placement of diabetes education program in facility		
Program Manual		
Documents description of (at a minimum):		
Organizational structure, mission statement, goals, annual plan, description of educational team/process, follow-up and other program components		
Signed by the appropriate personnel/departments		
There is a process in place for manual review and update		
Approval mechanism is documented for program and policy changes		
Evidence includes team meeting minutes, position descriptions, interdepartmental meetings and communications, registry, program policies, organization chart and program manual		

Comments:

LEVEL 3 (STANDARD 1, continued)	EVIDENCE YES	EVIDENCE NO
Team membership is expanded to include clinical, educational, public health and community representatives.		
There is a **coordinated approach** to diabetes management and education.		
There is documentation of **integration of diabetes education and medical standards** of care.		
Diabetes registry is expanded to include general registry and complications. Other registries are developed to help track target populations (ESRD, HTN, gestational, etc.)		
Registries are updated annually		
Organizational chart shows placement of diabetes program in the organizational structure of the facility		
Program manual is expanded to describe education and clinical components for diabetes prevention and management		
Manual also includes written statements regarding:		
Team commitment to *National Standards for DSME* and *IHS Standards of Care for Patients with Type 2 Diabetes*		
Administrative commitment to *National Standards for DSME* and *IHS Standards of Care for Patients with Type 2 Diabetes*		
Tribal commitment to address diabetes prevention and management		
Evidence includes team meeting minutes, program policies, program manual, curricula and lesson plans, patient education records, registries and organizational chart		

STANDARD 2	EVIDENCE YES	EVIDENCE NO
LEVEL 1		
Tasks needed to develop the education program are identified		
Community assessment for diabetes education needs completed		
Target population and its educational needs identified		
Diabetes education **program goals and objectives** are identified		
Diabetes education **resource assessment** completed		
Resource requirements are identified:		
Space		
Staffing		
Budget		
Instructional material		
Diabetes related training (staff)		
Evidence includes written community and resource assessments, task timelines, written description of target population, annual program plan and advisory body(s) minutes		
LEVEL 2		
Educational program goals and objectives are established and documented annually:		
Goals/objectives are realistic and measurable		
Goals/objectives are consistent with target population needs		
Progress towards meeting goals/objectives is evaluated		
Resources sufficient to meet program goals and objectives continue to be identified and provided		
Services meet needs of **target population**		
Consumer access to education program is defined and documented		
Evidence includes advisory body(s) meeting minutes, annual program plan, annual program evaluation and program policies		

Comments:

	EVIDENCE YES	EVIDENCE NO
LEVEL 3 (STANDARD 2, continued)		
Diabetes prevention and control services are considered at primary, secondary and tertiary prevention levels and continue to meet the needs of the target population		
Program **goals and objectives** are expanded to include community and clinical-based diabetes prevention and management		
Goals/objectives are based on **expanded community assessment** (such as audits, community forums, surveys, etc.) and include community and clinical-based diabetes prevention and management		
Resources for integrated diabetes program continue to be identified and provided		
Access to programs and services is further defined and documented		
Marketing strategies are developed to inform consumer of services		
There is a system which tracks participants **lost to follow-up** (educational and clinical)		
Evidence includes advisory body(s) meeting minutes, team meeting minutes, program policies, interdepartmental meeting minutes and communications, annual program plan, community assessment summaries and marketing materials		
STANDARD 3		
LEVEL 1		
Advisory body(s) identified		
Communication is documented		
Minutes reflect advisory body selection and methods is seek advice		
Composition reflects community served		
Composition includes medical, educational, community/consumer at a minimum		
Evidence includes advisory body(s) minutes and program policies		

	EVIDENCE YES	EVIDENCE NO
LEVEL 2		
There is a process that provides community and other advisory member input into the education program, including curricula and annual program plan, at least annually		
Evidence includes advisory body(s) meeting minutes and program policies		
LEVEL 3		
The advisory body(s) reviews and provides input annually to the diabetes program on curriculum, annual program plan and audit results		
There is evidence that policy recommendations have been forwarded to the administrative unit for **approval**		
Evidence includes advisory body(s) meeting minutes and program policies		
STANDARD 4		
LEVEL 1		
Coordinator is identified		
Coordinator is a credentialed health professional		
Appropriate education and experience is documented		
Responsibilities and line of authority are documented		
Evidence includes position description, curriculum vitae, continuing education records, licenses and credentials		

Comments:

LEVEL 2 (STANDARD 4, continued)	EVIDENCE YES	EVIDENCE NO
The coordinator manages educational team efforts, including development of goals and objectives		
The coordinator acts as diabetes education **liaison between team members,** departments or programs, and the community		
Coordinator's position description and annual employee evaluation **reflect roles and responsibilities**		
Coordinator documents **CEU activity** (minimum of 12 hours/2yr in diabetes, educational principles or leadership/management)		
Evidence includes position description, team meeting minutes, advisory body(s) meeting minutes, annual employee evaluation and continuing education records		
LEVEL 3		
Coordinator is liaison between multidisciplinary team, programs and departments providing comprehensive diabetes services		
Coordinator's **role expands** to include managing the diabetes education program and being a leader or team member in clinical and/or community diabetes programming		
Coordinator leads or helps with diabetes care and education outcome **audits** and diabetes surveillance system monitoring		
Evidence includes position description, team meeting minutes, interdepartmental meeting minutes and communications, and program policies		

STANDARD 5	EVIDENCE YES	EVIDENCE NO
LEVEL 1		
Instructional team members identified		
Instruction team includes **RN and RD** minimum		
Program manual documents instructional staff, credentials, roles and responsibilities		
Evidence includes instructional team listing in program manual, program policies, position descriptions, curriculum vitaes, continuing education records, licenses and credentials		
LEVEL 2		
Instructors maintain diabetes education services for **target population** based on identified needs		
Instructors use a variety of **teaching/learning methods**		
There is evidence of **team review and approval of education materials,** teaching methods and activities		
Evidence includes curricula and lesson plans, community needs assessments and team meeting minutes		
LEVEL 3		
Instructional team provides **multifaceted diabetes eduction** that includes integration of traditional and western methods of teaching/learning activities		
Evidence includes curricula and lesson plans, and patient education record (medical record)		

Comments:

STANDARD 6

LEVEL 1

Instructors have or are **updating knowledge and skills** in diabetes in American Indian/Alaska Native communities

Instructors have knowledge, skills and abilities in behavioral interventions, teaching/learning and counseling/communication

Evidence includes curriculum vitaes, continuing education records, licenses and credentials

LEVEL 2

Instructors document CEU activity (minimum of 12hours/2yr) in diabetes management, behavioral interventions, teaching/learning skills and counseling skills

Evidence includes continuing education records

LEVEL 3

Team members participate in yearly diabetes management, behavioral interventions, teaching/learning/counseling skills workshops and in-service programs relevant to American Indians/Alaska natives

Evidence includes continuing education and facility in-service records

STANDARD 7

LEVEL 1

Diabetes education **curricula** are identified and reviewed

Curricula meet community needs

Curricula include written measurable learning objectives, content outline, instructional methods, materials and means of achieving objectives

Content includes ten content areas of *National Standards*

Evidence includes written curricula and lesson plans

LEVEL 2

Curricula and educational resources are in place and reviewed annually by instructional team for scientific accuracy and cultural relevancy

New materials are field tested for relevancy and comprehension

Interpreters are oriented on a regular basis (as appropriate)

Evidence includes curricula, material review revision dates, field testing summary, interpreter list and program policies

LEVEL 3

There is **documentation of medical, public health staff, and community participation** in curricula review and adaptation

Evidence includes advisory body(s) meeting minutes

STANDARD 8

LEVEL 1

Instructional team develops an **individualized needs assessment** process

A form is developed to document process

Documentation includes relevant medical history, cultural influences, health beliefs and attitudes, diabetes knowledge/skill, readiness to learn, preferred learning method, barriers to learning, family support and financial limitations

Evidence includes documentation on a needs assessment form in the patient education record (medical record)

Comments:

	EVIDENCE YES	EVIDENCE NO
LEVEL 2 (STANDARD 8, continued)		
Instructional team uses standard diabetes **education assessment** process and documentation form		
Education assessment is individualized		
The **needs assessment** is the basis for initial and ongoing written educational plan		
Instructional team periodically reassesses individuals		
Evidence includes documentation of education process in the patient education record (medical record)		
LEVEL 3		
Individual/family ongoing diabetes care needs are systematically addressed in case management or other organizational diabetes best practice		
Evidence includes program policies and patient educational record (medical record)		
STANDARD 9		
LEVEL 1		
Diabetes education forms are identified as part of the **medical record**		
Instructors and coders are familiar with **diabetes education codes (RPMS preferred)**		
Team agrees that **SOAP charting** is the education documentation method of choice		
Program manual identifies policies and procedures regarding transfer of **confidential medical record** information		
Evidence includes documentation in patient education record (medical record) and program policies		

	EVIDENCE YES	EVIDENCE NO
LEVEL 2		
The **teaching process** (assessment, planning, implementation and evaluation of individualized educational experience) is **documented** in the medical record		
Documentation of education shows **collaboration** among educational team		
Evidence includes documentation of education process in the patient education record (medical record)		
LEVEL 3		
Medical records contain information regarding an individual's diabetes education and clinical care		
Team members are oriented and updated on diabetes documentation and coding issues		
Documentation includes services provided to community		
Evidence includes the patient education record (medical record), continuing education records and facility in-service records		
STANDARD 10		
LEVEL 1		
There is documentation of program goals and objectives, including desired **program outcomes**		
Program evaluation includes a minimum of **(1) behavioral and (2) clinical indicators**		
Program evaluation design allows for **pre and post-program measures**		
A process is in place for **evaluating consumer satisfaction**		
Evidence includes advisory body(s) minutes, program policies, annual program plan, CQI plans/data reports and consumer satisfaction survey/data/reports		

Comments:

	EVIDENCE YES	EVIDENCE NO
LEVEL 2 (STANDARD 10, continued)		
There is documentation of **progress towards goals and objectives,** including 2 clinical and 1 behavioral outcome indicators		
There is documentation of the appropriate **advisory body review** and input on outcomes, evaluation plan and program modifications		
Program records document, at a minimum, population served, types of service, length of participation, setting, content and age		
There is documentation that **action is taken** as a result of **program evaluation and consumer review** and evaluation		
Evidence includes advisory body(s) meeting minutes, program policies, program manual and annual evaluation summary		
LEVEL 3		
Medical records are reviewed annually using **IHS Diabetes Care and Outcomes Audit or similar** system		
Educational indicators are expanded/modified annually (within facility capability)		
Community-based programs have an annual program evaluation or surveillance system in place		
CQI data are shared with established advisory body(s), appropriate tribal leaders, community diabetes prevention systems and tribal community		
Program evaluation/outcome results are used in annual program planning		
Evidence includes annual audit summary, community program evaluation summaries, CQI reports and advisory body(s) meeting minutes		

Comments:

Section 5

Program Review Application and Instructions

As you prepare for *IHS Diabetes Education Program Recognition or IHS Integrated Diabetes Program Recognition,* please check the IHS National Diabetes Program web site at: www.ihs.gov/medicalprograms/diabetes for application updates.

Diabetes Program Review Application

This application is your request to the Indian Health Service (IHS) National Diabetes Program to review your diabetes program. Any Indian health facility (IHS, Tribal or Urban) is eligible to apply. Your program can request a review by completing this application.

As you prepare for *IHS Diabetes Program Recognition,* please check the IHS National Diabetes Program web site at: www.ihs.gov/medicalprograms/diabetes for application updates.

You can send the completed application and supporting documents in one of the following ways:

1. Electronic submissions: send completed application and supporting documents in PDF or MS Word format to: diabetesprogram@mail.ihs.gov

   or

2. Hard copy submissions: send four (4) copies of completed application and supporting documents to:
   IHS National Diabetes Program
   5300 Homestead Road
   Albuquerque, NM 87110

You will receive notification of your program review outcome within twelve (12) weeks of receipt of the complete application at the IHS National Diabetes Program.

If you have questions about how to complete your application please contact:

IHS National Diabetes Program
505 248-4182
diabetesprogram@mail.ihs.gov

Application Documents

Each applicant must attach the following:

Administrative

- ❑ Resolutions or support letters from Tribal and Program Administration documenting support for diabetes education programming and diabetes team approach to education and care
- ❑ Organizational Chart
- ❑ Program description and annual plan (past year)
- ❑ Minutes of one team meeting (past year)
- ❑ Minutes of one advisory body meeting which reflects program review and planning (past year)

Position Descriptions

- ❑ Diabetes Coordinator
- ❑ Diabetes Team Members (RN, RD, and Primary Provider required with application)
- ❑ Diabetes Instructional Team (RN and RD required with application)

Profiles (forms available within application)

- ❑ Education Program Profile
- ❑ Diabetes Coordinator Profile
- ❑ Instructor Profiles

Educational Materials

- ❑ Program brochure or other marketing materials
- ❑ Curriculum (if not on list of IHS approved curriculums)
- ❑ Education Documentation Forms

Program Evaluation

- ❑ Performance Improvement Report or similar evaluation for one behavioral outcome tracked in past year
- ❑ Diabetes Care and Outcomes Audit or similar report on one or more clinical outcomes tracked in past year

Note: Programs applying for *IHS Integrated Diabetes Program Recognition* will need to check the IHS National Diabetes Program web site: www.ihs.gov/medicalprograms/diabetes for further instructions.

First Edition (Revised 2001)

Date of Application:_____

Is this your first application? __Yes -or- Reapplication? __Yes

Application type (check one): ___Educational ____Integrated (educational, clinical and public health)

Date diabetes education program began services (month and year): _____

Name of Diabetes Education Program: _____
(This is the name that will appear on your Recognition Certificate.)

Sponsoring Organization/Facility:_____

Tribal Affiliation(s):_____

Address:_____ City:_____ State:_____ Zip:_____

The following questions apply to diabetes program services in your community:

Diabetes Coordinator
The coordinator is the contact person for this application.
(Attach coordinator position description and coordinator profile.)

Name: _____ Credentials:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone Number:_____ Fax:_____ Email:_____

Diabetes Team
List diabetes team members active in the past year (attach position descriptions for RN, RD, and Primary Provider team members):
Names: Dates served:

List dates of diabetes team meetings in past year (attach minutes of one team meeting):

List diabetes education instructors who taught during the past year (minimum RN and RD profile, attach other profiles if instructors teach more than 10% of content):
Names: Dates served:

Community Diabetes Program Needs Assessment Method(s)

What methods have you used in the past year to assess diabetes program needs for your community? (check all that apply)

___ Diabetes Registry
___ Community forum
___ Diabetes Advisory Body(s) feedback
___ Diabetes Care and Outcomes Audit
___ Community focus groups
___ Other community information (please describe)
___ Other utilization analysis (please describe)
___ Consumer feedback

Diabetes Program Advisory Body

What advisory body system do you use? (check all that apply)

___ Tribal Health Board/Committee
___ Tribal Council
___ Clinic Governing Body
___ Diabetes Advisory Council
___ Other (please give title)

Does the advisory body annually review program data, goal achievement, mission, organizational structure, target population, resources, quality improvement and plan services with the team based on this review?
Yes___ No___

List dates of advisory body(s) meetings during past year:
(Attach minutes that reflect diabetes program review and program planning within advisory system.)

Diabetes Education Program

(Attach program description and annual plan from within past year.)

Where do you provide diabetes education services? (check all that apply)

Clinic or hospital setting:
___ Freestanding Clinic
___ Hospital Outpatient
___ Hospital Inpatient
___ Other (describe)

Community-based setting:
___ Community Education Center
___ Elder Center
___ Community Wellness Center
___ Other (describe)

Target Population: (check all that apply)

___ New diagnosis
___ Youth
___ Adult
___ Elder
___ Gestational
___ Other (describe)

Are program resources (budget, staff, materials, etc.) adequate to meet community needs?
Yes___ No___

Access to Diabetes Education Program
(Attach program brochure or other marketing materials.)

Briefly describe how your community gains access to the diabetes education program:

Please describe at least one strategy your program has used to improve access:

Curriculum
(Attach copy of curriculum if not on list of curriculums approved by IHS.) Approved IHS curriculums include: Life with Diabetes (ADA), Basics (IDC), Claremore Model Diabetes Program, Albuquerque Model Diabetes Program, Muscogee (Creek Nation) Diabetes Program and Gila River Model Diabetes Program.

Name of curriculum used:_____

Briefly describe any modifications you made to curriculum or educational materials to meet the needs of your community:

Instructional Methods
What percent of participants receive diabetes education services in:
___ Group (2 or more people) sessions only
___ Individual sessions only
___ Combination group and individual

Are any of the following methods of sharing and learning about diabetes used in your community? (check all that apply)
___ Talking Circles
___ Storytelling (community member)
___ Traditional healer/religious leader
___ Traditional food and fitness practices
___ Resource use (elders, tribal leaders, CHR, nutrition assistant, etc.)
___ Other (describe):

Client Records and Documentation
(Attach forms used to document education process in your community.)

Do your facility education records include all of the following? ___Yes___ No
-Individualized needs assessment (covering elements described in Standard 8)
-Education plan
-Educational interventions
-Periodic evaluation of progress
-Collaboration with team

Does your facility use the diabetes education codes for RPMS? ___Yes ___No

Diabetes Education Program Impact and Outcome Evaluation
Check all data elements used:

___ General Registry
___ Complications Registry
___ Gestational Registry
___ Diabetes Care and Outcomes Audit
___ Educational Audit (RPMS generated)
___ Other (describe):

Briefly describe diabetes program evaluation and/or CQI activities during the past year:

What behavioral outcome(s) does your program track annually? (check all that apply)

___ Food and nutrition related
___ Fitness related
___ Self blood sugar monitoring
___ Medication use
___ Foot care
___ Sick day care
___ Tobacco use
___ Follow-up services

(Attach report for one behavioral outcome tracked in past year.)

What clinical outcomes does your program track annually?
___ All elements in IHS Diabetes Care and Outcomes Audit
___ Some elements in IHS Diabetes Care and Outcomes Audit (please list elements tracked)

(Attach report for one clinical outcome tracked in past year.)

The information in this application is true and accurately describes the Diabetes Self-Management Education services for which the sponsoring organization is seeking recognition.

_____ _____

Chief Administrative Officer
Sponsoring Institution

Coordinator
Diabetes Education Program

Diabetes Coordinator Profile

Name of Diabetes Education Program: _____

Coordinator Name:_____

Date started as Coordinator:_____

Total hours **per week** spent working in the Diabetes Education Program:_____

Certified Diabetes Educator: Yes ___ No ___ If CDE, date of last certification: _____

Degrees (may attach CV or resume):

License, registration and/or other certification (list type, may attach CV or resume):

List specific experience in the past three years in program management and care of persons with chronic disease (may attach CV or resume):

List continuing education credits received in past year (if not on CV or resume):

Program Title	Sponsoring Organization	CE Hours

Are you also a Program Instructor? Yes ___ No ___

Instructor Profile

Name of Diabetes Education Program:_____

Instructor Name:_____

Position Title:_____ Date started as Instructor:_____

Total hours **per month** spent working in the Diabetes Education Program:_____

List curriculum content areas you taught in the past year:

Certified Diabetes Educator: Yes ___ No ___ If CDE, date of last certification: _____

Degrees (may attach CV or resume):

License, registration and/or other certification (list type, may attach CV or resume):

List specific experience in the past three years in diabetes education (may attach CV or resume):

List continuing education credits received in past year (if not on CV or resume):

Program Title	Sponsoring Organization	CE Hours

Education Program Profile

Name of Diabetes Education Program:_____

The data period for this profile may be any 12-month period ending within three months of this application. Information in the profile should be from the data period you choose.
Data Period: _____(month/day/year) to _____(month/day/year)

Total number of program participants: a_____
Number completing comprehensive* program: b_____
Number completing only partial** program: c_____

*(Comprehensive includes needs assessment, educational interventions per education plan, periodic follow-up evaluation.) **(Partial includes only some of the components of comprehensive program.)

Average number of hours of diabetes self-management education received by a participant who:
Completed comprehensive program: d_____
Completed only partial program: e_____

For each category below, enter the number of participants served during the data period who completed a comprehensive program. Total number equals "b" above.

Classification and Age	<-19 years	20-44 years	45-64 years	>-65 years
Type 1	_____	_____	_____	_____
Type 2	_____	_____	_____	_____
Gestational	_____	_____	_____	
Other (describe)***	_____	_____	_____	_____
Total number each age	_____	_____	_____	_____

Total number all ages _____ (=b)
***(Other may include IGT, family members, etc.)

Age and sex	<-19 years	20-44 years	45-64 years	>-65 years
Male	_____	_____	_____	_____
Female	_____	_____	_____	_____

Total number males:_____ Total number females:_____ Total number male and female:_____(= b)

Education Setting
(Please tell us the number of contacts 1:1, and in group.)

	1:1	Group
Clinic or hospital setting		
Freestanding Clinic	_____	_____
Hospital Outpatient	_____	_____
Hospital Inpatient	_____	_____
Other (describe)	_____	_____
Community-based setting		
Community Education Center	_____	_____
Elder Center	_____	_____
Community Wellness Center	_____	_____
Other (describe):	_____	_____
Total number each setting	_____	_____
Total number all settings	_____ (= b)	

Race/Ethnicity

American Indian and Alaska Native	_____
Non-Indian	_____
Total	_____ (= b)

Section 6

Program Listing

Healthy Behaviors Form

Diabetes Health Assessment Form

Indian Health Diabetes Self-Management Education

Referral Form

Diabetes Education Assessment Form

Program Listing for Sample Forms

The following section contains samples of diabetes education forms. Your program may adapt or modify these forms for your local use.

Here is a listing of other program you can contact for diabetes education forms (tribal resolutions, support letters, needs assessment tools, education documentation, consumer surveys, post program assessments, etc.

UIHS, Inc. Diabetes Program
United Indian Health Services, Inc.
Tsurai Health Center
PO Box 420
Trinidad, California 95570-0420
Phone: (707) 677-4180
Fax: (707) 677-3170

Warm Springs Diabetes Program
Warm Springs Health and Wellness Center
PO Box 1209
Warm Springs, Oregon 97761
Phone: (541) 553-2478
Fax: (541) 553-2457

Winnebago Diabetes Program
Whirling Thunder Wellness Program
PHS Indian Hospital
Winnebago, Nebraska 68071
Phone: (402) 878-3187
Fax: (402) 878-2535

Albuquerque Diabetes Program
PHS Indian Hospital
801 Vassar Drive, NE
Albuquerque, New Mexico 87106
Phone: (505) 248-4017
Fax: (505) 248-7697

Claremore Diabetes Program
PHS Indian Hospital
Claremore, Oklahoma 74017
Phone: (918) 342-6451
Fax: (918) 342-6585

San Carlos Indian Hospital
PO Box 208
San Carlos, Arizona 85550
Phone: (520) 475-2686
Fax: (520) 475-7377

Muskogee Indian Health Center
212 South 38th
Muskogee, Oklahoma 744401
Phone: (918) 756-3334
Fax: (918) 687-0665

Gila River Diabetes Education Center
Hu Hu Kam Memorial Hospital
PO Box 38
Sacton, Arizona 85247
Phone: (520) 562-3321, ext. 1553
Fax: (602) 528-1245

Navajo Area Diabetes Center at Shiprock
Northern Navajo Medical Center
PO Box 160
Shiprock, New Mexico 87420
Phone: (505) 368-7425
Fax: (505) 368-7426/6260

IHS Diabetes Education Codes-web site
www.ihs.gov/medicalprograms/healthcare/clinicalguidelines/ProvPtEd.asp

IHS National Diabetes Program-web site:
www.ihs.gov/medical programs/diabetes

SAMPLE

Healthy Behaviors

Please date the box that best describes your diabetes self care behaviors in the areas listed below.

Eating Well	Thinking about it	Ready to start	Doing it now	Doing for 6 months
I limit high-fat foods or fried foods like french fries, chips, bologna or sausage to 1 or 2 serving per week.				
I limit sweet foods like cake, pies and candy to small servings on special occasions.				
I limit starchy foods like potatoes, bread, corn, rice and pasta to 2 or 3 servings per meal.				
I drink diet pop or other sugar-free beverages.				
I eat second servings no more than twice a week.				
I eat at regular times, 4-6 hours apart.				

Being Active	Thinking about it	Ready to start	Doing It now	Doing for 6 months
I walk or do non-stop exercise for 30 minutes or more.				
I walk or do non-stop exercise 5-7 days per week.				
I find a way to exercise during bad weather.				
I increase my daily activities by doing yard work, gardening or walking short distances instead of driving.				
I play golf, bowl or do other leisure activities 2 or more times per week.				

Blood Sugar Testing	Thinking about it	Ready to start	Doing it now	Doing for 6 months
I test my blood sugar as planned.				
I keep my blood sugar before breakfast between 80-140.				
I keep my blood sugar after meals between 140-160.				
I record reasons for high blood sugar readings.				
I make changes to reduce my blood sugar.				
I bring my blood sugar monitor and testing log to clinic visits.				

Patient Identification:

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SAMPLE

Healthy Behaviors (page 2)

Foot Care	Thinking about it	Ready to start	Doing it now	Doing for 6 months
I wash my feet and rub them with lotion every day.				
I check my feet for cuts and sores.				
I cut my toenails straight across.				
I wear shoes with lace ups or Velcro™ straps.				
I wear shoes with firm cushioned soles.				

Coping with Stress	Thinking about it	Ready to start	Doing it now	Doing for 6 months
I consider more than one option before choosing a solution to a difficult problem.				
I talk with someone about things that make me feel uncomfortable.				
I exercise, pray, or do other things to relieve stress.				
I say "No" to offers of food not in my plan.				
I find a way to relax and enjoy something every day.				

Medical Care	Thinking about it	Ready to start	Doing it now	Doing for 6 months
I make appointments for routine diabetes check-ups.				
I keep my clinic appointments.				
I take my blood pressure and blood sugar medicine every day.				
I get refills on my medications before I run out.				
I ask about my lab results at clinic visits.				

Building Support	Thinking about it	Ready to start	Doing it now	Doing for 6 months
I share information with my family or friends so they can understand diabetes self care.				
I ask my family or friends to join me with making healthy eating choices and becoming more active.				
I attend support group meetings or other continuing diabetes education classes.				

Patient Identification:

SAMPLE

Healthy Behaviors (page 3)

Dental Care	Thinking about it	Ready to start	Doing it now	Doing for 6 months
I brush my teeth every day.				
I floss my teeth every day.				
I have my gums checked once a year.				

Personal Responsibility	Thinking about it	Ready to start	Doing it now	Doing for 6 months
I read magazines and books about diabetes self care.				
I ask questions about new treatments and products for diabetes self care.				

Below is a list of diabetes self care behaviors. Use the following scale to rate your confidence level for each of these behaviors.

1	2	3	4	5
Very little confidence		Confident	Quite a lot of confidence	

I can make my own decisions about self care options. ..... 1 ..... 2 ..... 3 ..... 4 5

I can keep my stress within healthy limits. ..... 1 ..... 2 ..... 3 ..... 4 5

I can find strength within myself for being healthy. ..... 1 ..... 2 ..... 3 ..... 4 5

I can manage my diabetes so that I can do things I enjoy. ..... 1 ..... 2 ..... 3 ..... 4 5

I can give my primary care provider a report of my self care. ..... 1 ..... 2 ..... 3 ..... 4 5

I can find ways to feel better when I am upset about having diabetes. 1 ..... 2 ..... 3 ..... 4 5

Patient Identification:

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SAMPLE

Diabetes Health Assessment

Please fill out the front and back of this form. Your answers will help guide your diabetes education to meet your individual needs. Please circle one answer for each question.

My beliefs about my health and diabetes:

My health is: ..... Excellent ... Good ..... Fair ..... Poor

I am concerned about my health: ..... A lot ..... Some ..... Hardly any .... None

I have this much control over my future health: ..... A lot ..... Some ..... Hardly any .... None

The changes I need to make to control my diabetes are: ..... Possible ... Difficult ..... Too difficult

I use traditional Indian ways to improve my health: ..... A lot ..... Some ..... Hardly any ... Never

I use healing practices other than Indian medicine and medical care: ... A lot ..... Some ..... Hardly any .... None

Can diabetes cause kidney failure? ..... Yes ..... No

Will I have problems in completing my diabetes education or coming to clinic for care?

I travel this many miles to the clinic _____

How I get to clinic: ..... My family or friend drives me ..... I drive myself ..... I ride a van or bus

I will have these problems in coming to my education or clinic visits:

I work nights ..... I have no sick leave ..... My boss will not like this ..... No problems ..... Other problems

How well do my friends and family support my efforts to control my diabetes?

I have family and friends that I can ask to help me: ..... Yes ..... No

They live in my house or nearby: ..... Yes ..... No

Names and relationship of persons(s) who will help me with my diabetes: _____

My close family and friends want to learn about diabetes: ..... Yes ..... No

My close family and friends encourage me to do the things which improve my health: ..... Yes ..... No

How much stress do I feel and how well do I control it?

My stress level has been: ..... (Low) 1 2 3 4 5 (High)

I eat or drink or smoke when I am stressed: ..... Yes ..... No ..... Sometimes

I exercise or do other helpful things to relieve stress: ..... Yes ..... No ..... Sometimes

What I do to relieve my stress works well: ..... Not at all ..... Now and then ..... Sometimes ..... Usually

Patient Identification:

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SAMPLE

Diabetes Health Assessment - Page 2

How do I feel about having diabetes?

Since I was told I have diabetes, I find that I often feel: (you may circle more than one)

Shock ..... Guilty..... Disbelief ..... Frustrated ..... Angry ..... Sad ..... No change Accepting ..... Other

I think my family feels this way about my diabetes: (You may circle more than one) ..... Shock ..... Guilty Disbelief ..... Frustrated ..... Angry ..... Sad ..... No change ..... Accepting .....Other

Having diabetes is:..... A disaster ..... A burden .....A problem..... A challenge .....An opportunity

How I like to learn:

I like to learn in these ways:(you may circle more than one) Watching slides/movies ..... Reading Others showing me how .....Discussions ..... Listening to others ..... Using computers Other _____

I like my diabetes education: ..... All at once ..... Over a few visits

I need someone to tell me what the information means in my native Indian language: ..... Yes .....No

If "Yes" (check one) _____ I can bring someone who speaks my language with me.

_____ I will need someone from the hospital staff to help.

How much confidence do I have in managing my diabetes?

I have confidence that I can make my own decisions about self care options.

..... (Very little) 1 2 3 4 5 (Quite a lot)

I have confidence that I can participate as an equal partner with the clinic staff in my diabetes care.

.....(Very little) 1 2 3 4 5 (Quite a lot)

I have confidence that I can make safe choices between self care or medical care.

.....(Very little) 1 2 3 4 5 (Quite a lot)

I have confidence that I can use health care services to meet my routine and urgent health needs.

.....(Very little) 1 2 3 4 5 (Quite a lot)

I have confidence that I can tell my doctor how my self care between visits affected my diabetes.

.....(Very little) 1 2 3 4 5 (Quite a lot)

I have confidence that I can find the strength within myself for being healthy.

.....(Very little) 1 2 3 4 5 (Quite a lot)

I have confidence that I can manage my diabetes so that I can do things I enjoy doing.

.....(Very little) 1 2 3 4 5 (Quite a lot)

I have confidence I can find ways to help me feel better when I feel upset about diabetes.

.....(Very little) 1 2 3 4 5 (Quite a lot)

Patient Identification:

Rev. 06/2001

SAMPLE

Indian Health Diabetes Self-Management Education Referral

Patient_____ **DOB** _____ **Phone contact #** _____

Chart Number_____

Address _____ **City/State/Zip**_____

Referring MD, DO, NP, PA: _____ **Ph#**_____

Type of Diabetes: __type 2 __type 1 __GDM __PGDM

Educational Necessity:

_____ Newly diagnosed diabetes

_____ Diabetes and pregnancy EDC _____

_____ Diabetes with complications/medical necessity

_____ Poor glycemic control (HgbA1C >8%)

_____ Hyperlipidemia (LDL>100, HDL<45/55)

_____ Nephropathy-MAU>30mgs/dl or Proteinuria

_____ Neuropathy /Insensate foot

_____ Retinopathy (Preproliferative, Microaneurysm)

_____ Cardiovascular disease (HTN, MI, CHF, CVA, PVD)

_____ **Review diabetes self –management skills post initial instruction**

_____ Change in treatment (describe):

_____ Insulin instruction

_____ **Diabetes Education Team**

To instruct on the following (based on assessment of educational needs):

- Disease process/treatment options
- Nutritional management
- Physical activity
- Medications
- Monitoring
- Preventing, detecting and treating acute complications
- Preventing, detecting and treating chronic complications
- Goal setting and problem solving
- Psychosocial adjustment
- Preconception care
- Management during pregnancy/ gestational diabetes management

Other (please explain) _____

_____

_____

_____

_____

Provider Signature _____ **Date** _____

Please attach copies (or list on reverse side) of current medication schedule and most recent labs (including HbA1c, lipid profile, urine albumin).

SAMPLE

Diabetes Education Assessment Form

Date:_____ Interviewer:_____

Diabetes History

Are there any family members that have diabetes? ❑ None
❑ Father ❑ Mother ❑ Siblings ❑ Aunt/Uncle ❑ Grandparents Comments: _____
Type of diabetes ❑ Type 2 ❑ Type1 ❑ GDM ❑ PGDM ❑ IGT
Date of diagnosis _____ Where?_____
Do you have any health problems because of your diabetes? ❑ Yes ❑ No Comments: _____
Have you had any previous diabetes education? ❑ Yes ❑ No
If yes, where?_____ When?_____
Have you seen a dietitian? ❑ Yes ❑ No Where?_____ When?_____
Blood glucose monitoring? ❑ Yes ❑ No Name of meter: _____
How often do you test?_____ What time of day? _____
Hemoglobin Alc _____ Date _____

Medical History

Do you have any of the following? ❑ No problems ❑ High BP ❑ High cholesterol ❑ Heart disease
❑ Eye problems ❑ Kidney problems ❑ Foot problems Other _____
What kind(s) of medication do you take for this?_____
Name _____ Dose _____ Time Taken_____
Name _____ Dose _____ Time Taken_____
Name _____ Dose _____ Time Taken_____
Any surgeries? _____
Known allergies (medicine/food)? _____
Weight change history _____
Women G ___ P ___ LC ___ AB ___ Last Pap smear:_____ Birth Control Method:_____

Method of Treatment

Eating habits:
Are you eating differently since you found out you have diabetes? ❑ Yes ❑ No
If yes, what types of changes have you made?
❑ Eat less ❑ Eat less fat ❑ Eat less sugar ❑ Eat more vegetables ❑ Drink less pop, juice
❑ Other _____
How many times a day do you eat? ❑ 1 ❑ 2 ❑ 3 ❑ Other _____
Which meals do you tend to skip? ❑ Breakfast ❑ Lunch ❑ Dinner
Who does the cooking in your house ❑ Self ❑ Spouse ❑ Other
Who does the shopping in your house? ❑ Self ❑ Spouse ❑ Other
How often do you eat out?_____

Addressograph:

SAMPLE

Method of Treatment (continued)

Exercise:

Type of exercise/activities _____ How many times a week?_____
Hours TV/Day _____

Diabetes medication:

Name _____ Dose _____ Time Taken_____
Name _____ Dose _____ Time Taken_____
Name _____ Dose _____ Time Taken_____
Are you having problems with your diabetes medication? ❑ Yes ❑ No
Comments_____
Any problems with: ❑ Low blood sugar ❑ High blood sugar ❑ None

Risk Factors

Tobacco User? ❑ Yes ❑ No ❑ Quit ❑ How many years? Type/amount? _____
Alcohol? ❑ Yes ❑ No ❑ Quit Number of drinks/week? _____

Socioeconomic

Present/Previous employment _____ Work hours _____
Financial concerns? ❑ Yes ❑ No Number of years of school completed _____
Possible barriers to learning: ❑ Vision ❑ Hearing ❑ Reading ❑ Language ❑ Stress ❑ Other
Comments_____

Support System

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other
# of people in household _____ Primary support person _____
Other support _____

Cultural Factors

Tribal affiliation _____ Tribal language spoken? ❑ Yes ❑ No
Comments_____

Health Care Utilization

Last PCP visit _____ Primary care provider _____
Eye exam _____ Dental exam _____
Foot exam _____ ER/Hospitalizations _____

6/01

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